



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

KELL WEST REGIONAL HOSPITAL
5420 KELL WEST BLVD
WICHITA FALLS TX 76310

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-13-0860-01

MFDR Date Received

DECEMBER 4, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We were not aware of this admission being related to a work injury. [Injured worker] did not tell Dr. Kamath's office or Kell West Regional Hospital prior to admission. He gave the Dr's office his Medicare card, which we found out later that his Medicare was termed. We were not aware of this being related to an old injury until day of discharge. Then at that we did call and obtain the information from adjustor Nora Salas... We did fax clinical at that time to start authorization. We should not be penalized for non-payment for lack of authorization. It was the employee fault for not letting the Dr's office and facility know of this prior to Surgery or admission."

Amount in Dispute: \$152,946.81

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor inpatient surgical services to the claimant then billed Medicare for that. According to the requestor Medicare indicated the claimant was no longer covered. At that point the requestor billed Texas Mutual for the services and attempted to obtain authorization for the surgery but none was obtained. Upon receipt of the bill Texas Mutual declined to issue payment absent preauthorization. The requestor argues 'We should not be penalized for non-payment for lack of authorization. It was the employee fault...' Be that as it may, the only exception that allows payment for a non-preauthorized inpatient admission is an emergency. And while the documentation submitted with the billing documents intractable pain it does not indicate or demonstrate that this pain was of sudden onset manifested by acute symptoms of sufficient severity, including service pain, that the absence of immediate medical attention could reasonably be expected to result in placing the patient' health or bodily functions in serious jeopardy, or service dysfunction of any body organ or part. Preauthorization was not obtained and the requestor's documentation does not substantiate the admission meets the definition of an emergency per Rule 133.2. Consequently, no payment is due."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy. 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 10, 2012	Inpatient Hospital Services	\$152,946.81	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the requirements for obtaining preauthorization.
3. Texas Labor Code §413.014 sets out procedures for reimbursement policies and guidelines; treatment guidelines and protocols.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 197 – Precertification/authorization/notification absent.
 - 240 – Preauthorization not obtained.
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - 891 – No additional payment after reconsideration.

Issues

1. Was preauthorization obtained for the inpatient hospital services?
2. Is the requestor entitled to reimbursement?

Findings

1. The respondent denied payment based upon lack of preauthorization. Review of the information submitted by the requestor finds the hospital alleges that it was unaware that the injury was work related. The injured worker provided his Medicare card, which the hospital later found out was not effective. Per 28 Texas Administrative Code §134.600(p)(1), inpatient hospital admissions, including the principal schedule procedure(s) and length of stay require preauthorization. Review of the documentation provided by the requestor finds no documentation to support preauthorization was obtained.
2. In accordance with Texas Labor Code §413.014(d), the insurance carrier is not liable for those specified treatments and services requiring preauthorization unless preauthorization is sought by the claimant or health care provider and either obtained from the insurance carrier or ordered by the commissioner. Review of the submitted documentation finds that the health care provider did not obtain preauthorization as required, for that reason the requestor is not entitled to reimbursement for the service in dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

October 1, 2013
Date

Signature

Director, Health Care Business Management

October 1, 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.